APPLICATION FOR MOTION PICTURE THEATER LICENSE

Name of applicant: First	Ŋ	Middle		Last
Address: Street	City	State	Zip	Phone Number
Corporate name of business:		DBA _		
Address of business:		Phone 1	Number:	
Minn. Tax ID Number:	Federal Tax ID Number:			
List any persons, corporations, or part	nerships wh	o have a financ	ial interest in	n this license:
Are you licensed in any other commun				
If yes, where?				
Have you been denied a license (for w Yes No	hich you are	e applying) by a	any licensing	g authority?
Are you currently under investigation	for any crim	ne? Yes	N	0
If yes, give information as to the date,	place and n	ature of offense	e for such in	vestigation
DATE DOWN GV NOTICE				
DATA PRIVACY NOTICE: The data you supply on this form will are not legally required to provide thi it. The data requested is not private of constitute a public record, and copies	is data, but v data under th	ve will not be a ne data privacy	ble to grant t law. The da	the license without
I have read the Data Privacy Notice a the application. I declare that the info understand that falsification of answe I authorize the City of Shakopee to in verify the information provided.	ormation I hers on this ap	ave provided of oplication will r	n the applica esult in deni	tion is truthful and lad of the application
Applicant Signature		Date		
Subscribed and sworn to before me the	his	day of		, 20
Notary Signature				

Form SP: C1 License Applicant

Pursuant to Minnesota Statute MS 270C.72 Tax Clearance: Issuance of licenses, the licensing authority is required to provide the Minnesota Commissioner of Revenue the business tax identification number and Social Security number of each applicant. Under Minnesota Government Data Practices Act and Federal Privacy Act of 1974, we are required to advise you of the following regarding the use of this information:

- 1 This information may be used to deny the issuance, renewal or transfer of your license in the event you owe the MN Dept. of Revenue delinquent taxes, penalties or interest.
- 2 Upon receiving this information, the licensing authority will supply it only to the MN Dept. of Revenue. However, the Federal Exchange of Information Agreement, the Dept. of Revenue may supply this information to the I.R.S.
- 3 Failure to supply this information may jeopardize or delay the processing of your licensing issuance or renewal application.

Please supply the following information and return along with you application to the agency issuing the license.

cense applied for or renewed:
censing Authority: (Example: City. County, State)
cense Renewal date:
Personal Information (If applicable)
oplicant's Name:
oplicant's Address:
cial Security Number:
Business Information (If applicable)
siness Name:
siness Address:
nnesota tax Identification Number:
deral Tax Identification Number: a MN Tax I.D. is not required, please explain on the reverse side of this form)
gnature Date

CERTIFICATION OF COMPLIANCE MINNESOTA WORKERS' COMPENSATION LAW

Minnesota Statute Section 176.182 requires every state and local licensing agency to withhold the issuance or renewal of a license or permit to operate a business in Minnesota until the applicant presents acceptable evidence of compliance with the workers' compensation insurance coverage requirement of MSS Chapter 176. The information required is: The name of the insurance company, the policy number, and dates of coverage or the permit to self-insure. This information will be collected by the licensing agency and put in their company files.

This information is required by law, and licenses and permits to operate a business may not be issued or renewed if it is not provided and/or is falsely reported. Furthermore, if this information is not provided and/or falsely stated, it may result in a \$1,000 penalty assessed against the applicant by the Commissioner of the Department of Labor and Industry.

Insurance Company Name:	
(NOT the insurance agent)	
Policy Number:	
Dates of Coverage:	to
OR	
I am not required to have wor	kers' compensation liability coverage because:
() I have no employees.	
() I am self-insured (include	e permit to self-insure)
	o are covered by the workers' compensation law Parents, Children and certain farm employees)
——————————————————————————————————————	provided above is accurate and complete and that a valid workers' ept in effect at all times as required by law.
Name:	
	(Last, First, Middle)
Doing Business As:	(Business name if different than your name)
	(Business name if different than your name)
Business Address:	
City, State, Zip:	Phone:
Signature:	Date: